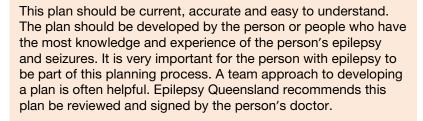
Epilepsy Management Plan

Name

Epilepsy Management Plan



Attach photo	
if required	

epilepsy

1.DATE	2.DATE TO REVIEW			
3.DATE OF BIRTH	CURRENT WEIGHT (kg)			
ADDRESS	POSTCODE			
PHONE	MOBILE			
EMAIL				
4.FIRST EMERGENCY CONTACT	NAME			
RELATIONSHIP	PHONE (Home)			
PHONE (Work)	MOBILE			
EMAIL				
SECOND EMERGENCY CONTACT	NAME			
RELATIONSHIP	PHONE (Home)			
PHONE (Work)	MOBILE			
EMAIL				
5.CURRENT EPILEPSY MEDICATI	ON			
5.CURRENT EPILEPSY MEDICATI NAME (eg sodium valproate)				
NAME (eg sodium valproate)	DOSE REGIME (eg 8am-200mg / 8pm-400mg)			
NAME (eg sodium valproate)				
NAME (eg sodium valproate)				
NAME (eg sodium valproate) COMMENTS				
NAME (eg sodium valproate) COMMENTS 6.HAS AN EMERGENCY EPILEPS	Y MEDICATION BEEN PRESCRIBED?			
NAME (eg sodium valproate) COMMENTS	Y MEDICATION BEEN PRESCRIBED?			

7.EPILEPSY DIAGNOSIS (if known)

SEIZURE DESCRIPTION
Name the type of seizure, if known, but more importantly, describe what happens before, during and after the seizure, remembering to include separate descriptions if the person has more than one type of seizure. Also, provide information about the duration and frequency of seizures.

Use additional pages if more space is required (available on request from Epilepsy Queensland).

8.SEIZURE TRIGGERS (if known)						
9.OTHER SEIZURE TREATMENTS Specific instructions/relevant informatio		Surgery		Ketogenic Diet	Vaga Nerve S	Stimulator (VNS)
10a.OTHER MEDICAL CONDITIONS						
10b.OTHER CURRENT MEDICATI	ION					
NAME (eg sodium valproate)		REGIME (eg 8am-	-200mg / 8pm-	400mg)		
11.SEIZURE FIRST AID PROCEDURE SPECIFIC TO THIS PERSON						

12. WHEN TO CALL AN AMBULANCE
13.POST-SEIZURE MONITORING
14.OTHER SPECIFIC INSTRUCTIONS

15.ENDORSEMENT BY ONE TREATING DOCTOR / EPILEPSY SPECIALIST (only ONE endorsement is required)

YOUR DOCTOR / SPECIALIST'S NAME		
SIGNATURE		
PHONE	MOBILE	DATE
EPILEPSY PLAN COORDINATOR		
NAME		
PHONE	MOBILE	DATE
	ODIEC	Ditte
16.PEOPLE INVOLVED IN PREPARATION	OF THIS PLAN	17.COPIES OF THIS PLAN ARE LOCATED AT
		DOCTOR
PERSON WITH EPILEPSY YES CONTACT NAME	NO	DOCTOR ADDRESS
RELATIONSHIP		ADDRESS
PHONE		PHONE
MOBILE		EMAIL
EMAIL		
CONTACT NAME		SCHOOL
POSITION		STAFF CONTACT
ORGANISATION		ADDRESS
PHONE		
MOBILE		PHONE
EMAIL		EMAIL
CONTACT NAME		OTHER
POSITION		CONTACT
ORGANISATION		ADDRESS
PHONE		
MOBILE		PHONE
EMAIL		EMAIL
CONTACT NAME		OTHER
CONTACT NAME		OTHER
POSITION		CONTACT
ORGANISATION PHONE		ADDRESS
MOBILE		PHONE
EMAIL		EMAIL
		_ =



For more information contact

Epilepsy Queensland Inc

Level 2, Gabba Towers, 411 Vulture Street, Woolloongabba Q 4102

phone (07) 3435 5000 or 1300 852 853

fax (07) 3435 5025

email services@epilepsyqueensland.com.au

 $\textbf{web} \ \text{www.epilepsyqueensland.com.au}$